

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12925 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12921

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Somerset</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne R.F.D.3</u> c. LENGTH OF STAY IN 1b <u>50 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Somerset</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne R.F.D. 3</u> d. STREET ADDRESS _____													
<b>3. NAME OF DECEASED</b> (Type or print) <u>Annie B. Dashiell</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>Nov. 24, 1958</u> Month Day Year													
<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 13, 1908</u>		<b>9. AGE</b> (In years last birthday) <u>50</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>Atwood Bozman</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Bessie Emory</u>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>						<b>16. SOCIAL SECURITY NO.</b> <u>219-03-59-3</u>						<b>17. INFORMANT</b> <u>Mr. Elmer Dashiell Princess Anne, Md.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Disease</u> <u>420.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>sudden</u>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>					
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , <b>Accident</b> <input type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> .																	
<b>ACTUAL SIGNATURE</b> <u>R. H. Johnson</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b> <u>11/25/58</u>					
<b>EXAMINER'S NAME (Type)</b> <u>R. H. Johnson, M.D.</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u>				<b>22b. DATE THEREOF</b> <u>11-26-1958</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Oriole Cemetery</u>				<b>22d. LOCATION (City, town, or county)</b> <u>Oriole, Maryland</u>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Levin B. Wilson</u>						<b>ADDRESS</b> <u>Princess Anne, Md.</u>						<b>24a. REC'D BY REGISTRAR</b> <u>1 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

STATE OF MARYLAND—Baltimore  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12926

## CERTIFICATE OF DEATH

Reg. Dist. No.

12922

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>				c. LENGTH OF STAY IN 1b <b>89 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne R.F.D.</b>			
				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Minnie</b> <b>M. Dashiell</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>23</b> Year <b>1958</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 24, 1869</b>	
9. AGE (In years last birthday) <b>89</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Robert Dashiell</b>				14. MOTHER'S MAIDEN NAME <b>Sallie Waller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT Address <b>Mrs Fred Kohlheim Princess Anne, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis of kidneys</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>7 weeks</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>o. 11.</b> Month, Day, Year <b>19</b> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Nov. 20</b> , 19 <b>58</b> , to <b>Nov 23</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 23</b> , 19 <b>58</b> , and that death occurred at <b>8P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Dames Quarter, Maryland</b> DATE SIGNED <b>11-25-58</b>							
ACTUAL SIGNATURE <b>Everett C Sutter</b>				M.D. <b>Dames Quarter, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Everett Sutter MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11-26-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>All Saint Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Venton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leon R. Wilson</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>Dec 1 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinner</b>			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BOSTON, JUNE 18

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12923

12921

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>318 Tyler St.</b>		d. STREET ADDRESS <b>318 Tyler St.</b>	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>F.</b> Last <b>DOWNING</b>		4. DATE OF DEATH Month <b>November</b> Day <b>28</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 3, 1877</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seafood Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Crab &amp; Oyster</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Gerald</b>		14. MOTHER'S MAIDEN NAME <b>Susan Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>216-14-2600A</b>	
17. INFORMANT Address <b>Augusta Henry, 2222 Turner St., Phila., Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Colon</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 27, 1958</b> , to <b>Nov. 28, 1958</b> that I last saw the deceased alive on <b>Nov. 27, 1958</b> , and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Sarah M. Peyton</b>		ADDRESS (Street, city or town, state) <b>334 W. Main</b> DATE SIGNED <b>11/29/58</b>	
PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton, M. D.</b>		<b>Crisfield, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 30, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		ADDRESS <b>334 W. Main</b>	
24a. REC'D BY REGISTRAR <b>DEC 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		45		1880		Michigan		Detroit		Michigan		United States	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
1234 Main St., Detroit, Mich.		Carpenter		Heart Disease		1925		Detroit		Michigan		Michigan		United States	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION		RACE		COLOR	
John H. Harris		Mary E. Harris		Elizabeth Harris		5 children		High School		Roman Catholic		White		Caucasian	
PREVIOUS ILLNESS		TREATMENT		PHYSICIAN		HOSPITAL		NURSE		CERTIFICATE		SIGNATURE		TITLE	
None		None		Dr. J. H. Smith		St. Mary's Hospital		Miss J. K. Brown		1234 Main St., Detroit, Mich.		J. H. Smith		Physician	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		FATHER		MOTHER		SPOUSE	
1925		Detroit		Michigan		United States		John H. Harris		Mary E. Harris		Elizabeth Harris		None	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delayed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12927

## CERTIFICATE OF DEATH

12924

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMORIAL HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HENRY G. ELLIOTT</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 26 1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-12-1861</b>
9. AGE (In years last birthday) yrs. <b>97</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>LEVEN ELLIOTT</b>	
14. MOTHER'S MAIDEN NAME <b>LAURENE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None None</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>NORA WINDSOR</b> Address <b>MARION STATION, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Acute Dist Heart</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral infarction</b> DUE TO (c) <b>Chronic myocarditis Chronic Dist myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>17 days</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy of nose duration 10 years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 20</b> , 19 <b>58</b> , to <b>11-26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-26</b> , 19 <b>58</b> , and that death occurred at <b>3:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>George C. Coulbourn</b> M.D. <b>MARION, MARYLAND</b> PHYSICIAN'S NAME (Type) <b>GEORGE C. COULBOURN, M.D.,</b> <b>MARION, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 29, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Marion Station, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 3 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12928

## CERTIFICATE OF DEATH

Reg. Dist. No.

12925

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>home</b>				d. STREET ADDRESS <b>R.F.D. 1. Box 252 A</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Thomas Evans</b>				4. DATE OF DEATH <b>November 11 1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9, 1882</b>		9. AGE (In years last birthday) <b>76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Silas Evans</b>				14. MOTHER'S MAIDEN NAME <b>Augusta Tull</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218 14 4027</b>		17. INFORMANT <b>Albert Evans, Marion, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Essential Hypertension</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b> <b>10 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/22/1958</b> to <b>10/31/1958</b> , that I last saw the deceased alive on <b>10/31/1958</b> , and that death occurred at <b>9:40 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Becil A. Duveney M.D.</b>				ADDRESS (Street, city or town, State) <b>11 S. 4th St, Bridgetown</b>		DATE SIGNED <b>11-3-58</b>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 6, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Peer</b>		22d. LOCATION (City, town, or county) (State) <b>Marion, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar Wharton</b>				ADDRESS <b>New Church, W.V.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 10 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be deleted and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2112

218

General  
Coroner

General Hospital

10/31

10/28 10/31  
J. H. H.

10/28 10/31  
J. H. H.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12929

## CERTIFICATE OF DEATH

12926

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>				c. LENGTH OF STAY IN 1b <b>3 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>JASPER</b> Last <b>FORD</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>13</b> Year <b>1958</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/27/1880</b>		9. AGE (In years last birthday) yrs. <b>78</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>For Himself</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>WILLIAM FORD</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Crosley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>186-142-448</b>		17. INFORMANT Address <b>MARY FORD, MARION, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.1</b> DUE TO <b>Coronary Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis Chronic Id. Infarct</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>20 days</b> <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-13</b> , 19 <b>58</b> , to <b>11-13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-12</b> , 19 <b>58</b> , and that death occurred at <b>12:45 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MARION, MARYLAND</b> DATE SIGNED							
ACTUAL SIGNATURE <b>George C. Coulbourn</b> M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>G. C. COULBOURN, M.D.</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 15, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunnuridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>				24a. REC'D BY REGISTRAR <b>NOV 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1933

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Cause of Death		Duration of Illness		Time of Death	
Place of Death		Occupation		Signature of Physician	
Signature of Registrar		Date of Registration		Official Seal	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12930

## CERTIFICATE OF DEATH

12927

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARION STATION</b>	
3. NAME OF DECEASED (Type or print) First <b>BLANCHE</b> Middle <b>BEAN</b> Last <b>GORDON</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>12</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-1889</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES BEAN</b>		14. MOTHER'S MAIDEN NAME <b>ESTELLE KAUFFMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>FLOYD GORDON</b>		Address <b>MARION, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage - 331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio-sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour - yes -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1956</b> , to <b>1958</b> , that I last saw the deceased alive on <b>Nov 12, 1958</b> , and that death occurred at <b>4:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CRISFIELD, MARYLAND</b> DATE SIGNED			
ACTUAL SIGNATURE <b>C. G. Rawley</b> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>C. G. RAWLEY, M.D.</b>		DATE SIGNED <b>CRISFIELD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 14, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Marion Station, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 17 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			





**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12931 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12928

Reg. Dist. No.

**FOR STATE  
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD, Pocomoke</b>		c. LENGTH OF STAY IN lb <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD, Pocomoke</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Home</b>				d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THEODORE</b>		First Middle Last <b>- HORSEY</b>		4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 8, 1904</b>		9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Dixon</b>				14. MOTHER'S MAIDEN NAME <b>Harriett Horsey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Horsey</b> Address <b>Sally Taylor, RFD, Pocomoke, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line in (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broken Neck.</b> <b>825X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>825X</b> DUE TO cause lost. (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile Accident</b>					
20c. TIME OF INJURY Month, Day, Year <b>10:30 p.m. - 11-8-58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) <b>County Road Pocomoke RFD Somerset Md</b>		20f. (City or town) (County) (State) <b>Pocomoke RFD Somerset Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>R. H. Johnson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11/10/58</b>	
EXAMINER'S NAME (Type) <b>R. H. Johnson, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 12, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Christ ME Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>RFD, Pocomoke, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>				ADDRESS <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 13 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

12-13

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12-13

12-13

Barbara J. Lee

Barbara J. Lee

Barbara J. Lee

10-11-8 58

R. H. Lee

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12932

CERTIFICATE OF DEATH

Reg. Dist. No.

12929

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.F. D. Marion</b>		c. LENGTH OF STAY IN 1b <b>since 1904</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>MATTIE</b> Middle <b>L.</b> Last <b>HUDSON</b>		4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 14, 1878</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Berlin, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John F. Jones</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Crippin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Lawrence Burgess—R.F.D. Marion, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>170x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Breast</b> DUE TO (c) <b>Melastosis of Liver &amp; Lungs.</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug</b> , 1957, to <b>Nov 3</b> , 1958, that I last saw the deceased alive on <b>Oct 20</b> , 1958, and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Marion Sta Md</b> DATE SIGNED ACTUAL SIGNATURE <b>George C. Coulbourn</b> M.D. <b>Marion Sta Md</b> PHYSICIAN'S NAME (Type) <b>George C. Coulbourn, M. D.</b> <b>Marion Station, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 6, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rehobeth Presbyterian</b>		22d. LOCATION (City, town, or county) (State) <b>Rehobeth, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons—Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 10 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			



FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12922 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12930**

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cristfield</b>	c. LENGTH OF STAY IN 1b <b>39</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cristfield</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>609 Broadway</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Pearl Jackson</b>		4. DATE OF DEATH <b>Nov. 3, 1958</b>	
5. SEX <b>Fe.</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1901 Dec 15, 1901</b>
9. AGE (In years last birthday) <b>56 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Marumsc</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Canis McCready</b>		14. MOTHER'S MAIDEN NAME <b>Laura Teagle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Doris Johnson-Marion Sta., Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Disease and Arteriosclerosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>During Sleep</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (c) <b>William H. Coulbourn, M.D. DEPUTY MEDICAL EXAMINER FOR SOMERSET COUNTY, MD.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City (or town) (County) (State) <b>Cristfield Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. H. Coulbourn M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>Nov 4 - 1958</b>	
EXAMINER'S NAME (Type) <b>W. H. Coulbourn M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 7, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Marumsc</b>		22d. LOCATION (City, town, or county) (State) <b>Marumsc, Som. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Hard-Marion Sta., Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>NOV 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hard</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12933

CERTIFICATE OF DEATH

Reg. Dist. No. 12931

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ORIOLE</b>				c. LENGTH OF STAY IN 1b <b>Life Time</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>BESSIE E. LANE</b>				4. DATE OF DEATH Month <b>11</b> Day <b>6</b> Year <b>58</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/5/1878</b>	9. AGE (In years, month, day) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>TEACHER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>				13. FATHER'S NAME <b>JREMIAS MADDUX</b>			
14. MOTHER'S MAIDEN NAME <b>ELLENORE MCBRIDE</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>1899-2.6.1916</b>			
16. SOCIAL SECURITY NO. <b>089-2.6.1916</b>				17. INFORMANT Address <b>KENNITH LANE PRINCESS ANNE, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>  <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>uremia</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>11-1-58</b> , 19____, to <b>11-6-58</b> , 19____, that I last saw the deceased alive on <b>11-6-58</b> , 19____, and that death occurred at <b>7a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Dames Quarter, Maryland</b> DATE SIGNED <b>11-7-58</b> ACTUAL SIGNATURE <b>Everett C. Sutter</b> M.D. PHYSICIAN'S NAME (Type) <b>Everett C. Sutter MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/9/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ST JAMES</b>	22d. LOCATION (City, town, or county) (State) <b>ORIOLE MARYLAND</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>WILLIAM H. JAMES JR. PRINCESS ANNE, MD</b>			24a. REC'D BY REGISTRAR DATE <b>NOV 10 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12923 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 12923 CERTIFICATE OF DEATH

12932

Reg. Dist. No.

265

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>	c. LENGTH OF STAY IN 1b <u>LIFETIME</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HOME</u>		d. STREET ADDRESS <u>CHESAPEAKE</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>HATTIE OLEVIA LAWSON</u>		4. DATE OF DEATH Month Day Year <u>NOV 3 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 22 - 1871</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House hold</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ISAAC LAWSON</u>	
14. MOTHER'S MARDEN NAME <u>MARGARET Dougherty</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Lena Hickman Crisfield Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage - Acute Dil. of Heart + Atherosclerosis</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Atherosclerosis - Chronic</u> DUE TO <u>Out. Nephritis - C. Myocarditis</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 31</u> , 19 <u>58</u> , to <u>Nov. 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 2</u> , 19 <u>58</u> , and that death occurred at <u>9:25 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George C. Coulbourn MD</u> M.D.		ADDRESS (Street, city or town, state) <u>Marion Sta. Md.</u>	
PHYSICIAN'S NAME (Type) <u>George C. Coulbourn MD</u>		DATE SIGNED <u>11-3-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Nov. 5-1958</u>	22c. NAME OF CEMETERY <u>Asbury Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Crisfield Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Hannon</u>		ADDRESS <u>Crisfield Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hannon</u>	

# CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1925-01-15</u></p>		<p>4. Date of death: <u>1985-03-10</u></p>	
<p>5. Place of birth: <u>New York, NY</u></p>		<p>6. Place of death: <u>New York, NY</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1985-03-15</u></p>		<p>12. Office of registration: <u>New York City</u></p>	

12934

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>				c. LENGTH OF STAY IN 1b <b>82 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMORIAL HOSP.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <b>1 FIRST STREET</b>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>KATHRYN C. MASON</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 6 19 58</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-30-1876</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Christy</b>				14. MOTHER'S MAIDEN NAME <b>Betsy Marshall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>ELOISE MASON, CRISFIELD, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.9</b> <b>intestinal obstruction</b> DUE TO <b>Carcinoma, bowel</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>?</b> DUE TO (c) <b>?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1948</b> , to <b>1958</b> , that I last saw the deceased alive on <b>Nov 5</b> , 19 <b>58</b> , and that death occurred at <b>3:45</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CRISFIELD, MARYLAND</b> DATE SIGNED <b>C. G. Rawley</b>							
ACTUAL SIGNATURE <b>C. G. Rawley</b> M.D.				PHYSICIAN'S NAME (Type) <b>C. G. RAWLEY, M.D.</b> <b>CRISFIELD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 8, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Crisfield Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 10 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10



12935

## CERTIFICATE OF DEATH

12934

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMORIAL HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>----</b> Last <b>MENZEL</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>3</b> Year <b>58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-29-1907</b>
9. AGE (In years last birthday) yrs. <b>50</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATERMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT MENZEL</b>		14. MOTHER'S MAIDEN NAME <b>SUSANNA ECFORT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-40-8656</b>	
17. INFORMANT <b>HAZEL MENZEL</b>		Address <b>SHELLTOWN, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute dil. of heart</b> <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dissecting Aneurysm abd. aorti</b> DUE TO (c) <b>Arterio sclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>10 hrs.</b> <b>3</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemiplegia, incomplete</b> <b>Dys</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Nov 1</b> , 19 <b>58</b> , to <b>Nov 3</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 3</b> , 19 <b>58</b> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>C. G. Rawley</b>		M.D. <b>CRISFIELD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>C. G. RAWLEY, M.D.,</b>		<b>CRISFIELD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-7-58</b>	22c. NAME OF CEMETERY <b>St. Paul Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Rural Marion, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Watson</b>		ADDRESS <b>Pocomoke City, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kimes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH _____	
NAME OF DECEASED _____		SEX _____	
AGE _____		RACE _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS _____		CAUSE OF DEATH _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF DEATH _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF REGISTRAR _____		SIGNATURE OF WITNESS _____	

12936 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12935  
CERTIFICATE OF DEATH

Reg. Dist. No. 261-

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) First <u>Addie</u> Middle _____ Last <u>Outten</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29-1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Ghisfield MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Levin Johnson</u>		14. MOTHER'S MAIDEN NAME <u>HARRIT STERLING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Rachel Jones</u> Address <u>Crisfield, Md. Rt. 2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Dilatation of Heart (Coronary death)</u> 592 X DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Int. nephritis - C. Myocarditis</u> DUE TO _____ (c) <u>General Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> years _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Nov 2</u> , 19 <u>58</u> , to <u>Nov. 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 4</u> , 19 <u>58</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George C. Coulbourn</u> M.D.		ADDRESS (Street, city or town, state) <u>Marion Sta. Md.</u> DATE SIGNED <u>11-6-58</u>	
PHYSICIAN'S NAME (Type) <u>George C. COULBOURN MD</u>		<u>MARION STATION MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Nov. 7, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Family</u>	22d. LOCATION (City, town, or county) (State) <u>Marion Station, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Hard</u> ADDRESS <u>Marion Sta., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Jones</u>	

# CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12937 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**CERTIFICATE OF DEATH**

12936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCESS ANNE</b>		c. LENGTH OF STAY IN 1b <b>TWO MONTH</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>MARIE</b> Last <b>ROBERTS</b>		4. DATE OF DEATH Month <b>II</b> Day <b>3</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/2/58</b>
9. AGE (In years lost birthday) yrs. <b>2</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>	
13. FATHER'S NAME <b>SHARMAN ROBERTS</b>		14. MOTHER'S MAIDEN NAME <b>BESSIE MULLIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>BESSIE MULLIN PRINCESS ANNE, MD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Enteric - Shingles</b> DUE TO <b>096.9</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Virus infection</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Marked Malnutrition + Dehydration</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>1 wk</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 27, 19 58</b> , to <b>Nov 3, 19 58</b> , that I last saw the deceased alive on <b>Nov 3, 19 58</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. C. Lewis</b>		DATE SIGNED <b>11/3/58</b>	
PHYSICIAN'S NAME (Type) <b>A. C. Lewis, M.D.</b>		ADDRESS (Street, city or town, state) <b>Main St, Princess Anne, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>II/4/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MT CARMAL</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCESS ANNE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WILLIAM H. JAMES JR</b>		ADDRESS <b>PRINCESS ANNE, MD</b>	
24a. REC'D BY REGISTRAR <b>NOV 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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CERTIFICATE OF DEATH

BOND





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12938  
CERTIFICATE OF DEATH

12937

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Accomack ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wachapreague 83x.3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DOA McCready Hospital		d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM THOMAS SCOTT		4. DATE OF DEATH Month Day Year November 30, 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY House Painting	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William D. Scott		14. MOTHER'S MAIDEN NAME Willie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No None		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Olevia B. Scott, Wachapreague, Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 30, 1958, to Nov 30, 1958, that I last saw the deceased alive on Nov 30, 1958, and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12/2/58 ACTUAL SIGNATURE Sarah M. Peyton M.D. 33 W. Main St - PHYSICIAN'S NAME (Type) Sarah M. Peyton, M. D. Crisfield, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 3, 1958	
22c. NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery		22d. LOCATION (City, town, or county) (State) Accomack, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		24a. REC'D BY REGISTRAR DATE DEC 3 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

# CERTIFICATE OF DEATH

10000

<p>1. Name of deceased                  [Name of deceased]</p>		<p>2. Sex                  [Sex]</p>	
<p>3. Date of birth                  [Date of birth]</p>		<p>4. Place of birth                  [Place of birth]</p>	
<p>5. Date of death                  [Date of death]</p>		<p>6. Place of death                  [Place of death]</p>	
<p>7. Cause of death                  [Cause of death]</p>		<p>8. Manner of death                  [Manner of death]</p>	
<p>9. Signature of physician                  [Signature of physician]</p>		<p>10. Signature of registrar                  [Signature of registrar]</p>	
<p>11. Date of registration                  [Date of registration]</p>		<p>12. Place of registration                  [Place of registration]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12939

### CERTIFICATE OF DEATH

Reg. Dist. No.

12938

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>				c. LENGTH OF STAY IN 1b <b>20 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>522 S. Somerset Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Sallie</b> Middle <b>Lankford</b> Last <b>Shields</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>4</b> Year <b>19 58</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1866</b>		9. AGE (In years lost birthday) <b>92 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin F. Lankford</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Porter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <b>Miss Amanda Lankford Princess Anne, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic myocarditis</b> DUE TO (c) <b>Arteriosclerosis (General)</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>2 yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. ft. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>54</b> , to <b>Nov 4</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 3</b> , 19 <b>58</b> , and that death occurred at <b>10:15 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. Frank Giganti</b>				ADDRESS (Street, city or town, state) <b>20 Prince William St. Nov 5, 1958</b>			
PHYSICIAN'S NAME (Type) <b>B. FRANK GIGANTI</b>				DATE SIGNED <b>PRINCESS ANNE Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>II-6-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Manokin Presbyterian</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leon Wilson</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 10 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

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12940

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Linden Ave., Ext'd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Robert</u> Last <u>Siddons</u>		4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer &amp; carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>South Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Frederick Siddons</u>		14. MOTHER'S MAIDEN NAME <u>Kate Hawley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>220-12-2264</u>	
17. INFORMANT <u>Mrs. Ethel Siddons - Linden Ave.-Princess Anne, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. H. Johnson</u>		DATE SIGNED <u>12/1/58</u>	
EXAMINER'S NAME (Type) <u>R. H. Johnson, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/2/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrews Episcopal</u>	22d. LOCATION (City, town, or county) (State) <u>Princess Anne, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Johnson</u>		24a. REC'D BY REGISTRAR <u>12/2/58</u>	
ADDRESS <u>Princess Anne Md</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

12345  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE			
DECEASED'S RESIDENCE		CITY		COUNTY		STATE			
DECEASED'S OCCUPATION									
DECEASED'S MARITAL STATUS									
DECEASED'S RELIGION									
DECEASED'S EDUCATION									
DECEASED'S SOCIAL STATUS									
DECEASED'S PREVIOUS ILLNESS									
DECEASED'S PREVIOUS SURGERY									
DECEASED'S PREVIOUS TRAUMA									
DECEASED'S PREVIOUS DRUGS									
DECEASED'S PREVIOUS ALCOHOL									
DECEASED'S PREVIOUS TOBACCO									
DECEASED'S PREVIOUS OTHER									
DECEASED'S PREVIOUS CAUSE OF DEATH									
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12924

## CERTIFICATE OF DEATH

Reg. Dist. No.

12940

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 Crisfield</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>701 W. Main St.</b>	
d. STREET ADDRESS <b>701 W. Main St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>FRANKLIN</b> Last <b>SNEADE</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>19</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 11, 1907</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Heating &amp; Plumbing</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>For Himself</b>	
11. BIRTHPLACE (State or foreign country) <b>Rhodes Point, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>David F. Sneade</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bradshaw</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>577-26-4357</b>	
17. INFORMANT <b>Mrs. Angeline M. Sneade-</b>		Address <b>701 W. Main St. Crisfield, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163X Tropic Myocarditis</b> DUE TO (b) <b>Insanition</b> DUE TO (c) <b>Squamous Cell Carcinoma of Tongue</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>One week</b> <b>then no known five mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Nov. 19 9-4-B.</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1958</b> to <b>Dec 16 1958</b> , that I last saw the deceased alive on <b>Nov. 16 1958</b> , and that death occurred at <b>6:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. N. Barr</b>		DATE SIGNED <b>11/22/58</b>	
PHYSICIAN'S NAME (Type)		M.D. <b>Crisfield, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 21, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Crisfield Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 26 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hous</b>	

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12941** Items 7, 8, 9 Film G235 11-13-58 et  
**CERTIFICATE OF DEATH**

**12941**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>				c. LENGTH OF STAY IN 1b <b>87</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ABRAHAM</b> Middle <b>SOMERS</b> Last <b>SOMERS</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>2</b> Year <b>1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1872 MAY 12, 1884/86/87</b> yrs. <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		9. AGE (In years last birthday) <b>86</b> yrs. <b>76</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>ABRAHAM SOMERS</b>				14. MOTHER'S MAIDEN NAME <b>SALLY NELSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Spanish-American</b>		17. INFORMANT <b>ANNIE BURKE</b>		Address <b>CRISFIELD, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Atherosclerosis</b> DUE TO (c) <b>Hypertrophied Prostate &amp; urinary retention</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Significant cystitis for retention</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 25, 1958</b> , to <b>Nov 2, 1958</b> , that I last saw the deceased alive on <b>Nov 2, 1958</b> , and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CRISFIELD, MARYLAND</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Sarah M. Peyton</b>		M.D. <b>CRISFIELD, MARYLAND</b>					
PHYSICIAN'S NAME (Type) <b>SARAH M. PEYTON, M.D.,</b>		<b>CRISFIELD, MARYLAND</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 5, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Crisfield Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>NOV 10 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		1910-01-15		New York, NY	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
1950-01-20		10:30 AM		Home		Dr. Smith		St. Mary's	
Burial Place		Burial Date		Burial Time		Burial Place		Burial Date	
St. Mary's		1950-01-22		10:00 AM		St. Mary's		1950-01-22	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Death Certifier	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12942** **CERTIFICATE OF DEATH**

**12942**

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>SOMERSET</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EDW. W. MCCREADY MEMO.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> <span style="float: right;">b. COUNTY <u>SOMERSET</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>39 CRISFIELD</u> d. STREET ADDRESS <u>1 TYLER STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ANNA</u> Middle <u>MAE</u> Last <u>STERLING</u>		<b>4. DATE OF DEATH</b> Month <u>NOVEMBER</u> Day <u>21</u> Year <u>19 58</u>					
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>NEGRO</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Aug 3-1900</u>		<b>9. AGE</b> (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>VA.</u>			
<b>10c. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>							
<b>13. FATHER'S NAME</b> <u>on known</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>on known</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Pyde Sterling, Crisfield Md</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>6 mos.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19 58</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____			
<b>20f. (City or town)</b> _____		<b>(County)</b> _____		<b>(State)</b> _____			
<b>21. I certify that I attended the deceased from</b> <u>Nov 20, 19 58</u> <b>to</b> <u>Nov 21, 19 58</u> <b>that I last saw the deceased alive on</b> <u>Nov. 20, 19 58</u> <b>and that death occurred at</b> <u>7:40 P.M.</u> <b>from the causes and on the date stated above.</b> ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
<b>ACTUAL SIGNATURE</b> <u>Sarah M. Peyton</u> <b>M.D.</b> <u>CRISFIELD, MARYLAND</u>		<b>PHYSICIAN'S NAME (Type)</b> <u>SARAH M. PEYTON, M.D.</u> <u>CRISFIELD, MARYLAND</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>NOV 24-58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>WARD'S</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>MARION, SOM, MD.</u>		<b>(State)</b> _____					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles Howard Marion Md.</u>		<b>ADDRESS</b> _____		<b>24a. REC'D BY REGISTRAR</b> DATE <u>DEC 1 '58</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





12943

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>VIRGINIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TANGIER</b> 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LILLIE</b> Middle <b>THOMAS</b> Last		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>18</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-29-1883</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM BROWN</b>		14. MOTHER'S MAIDEN NAME <b>BRITTANA BRYANT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>VIRGINIA CHARNOCK, TANGIER, VA.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Previous Myocardial Infarction</b> DUE TO (c) <b>Arteriosclerotic Heart Disease &amp; Hypertension</b> INTERVAL BETWEEN ONSET AND DEATH <b>One hour</b> <b>Ten days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/17</b> , 19 <b>58</b> , to <b>11/18</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/18</b> , 19 <b>58</b> , and that death occurred at <b>2 P.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. N. Barr</b> M.D.		ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b> DATE SIGNED <b>11/18/58</b>	
PHYSICIAN'S NAME (Type) <b>A. N. BARR, M.D.</b>		<b>CRISFIELD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>Burial</b>		<b>Nov. 21, 1958</b>	
22c. NAME OF CEMETERY OR CREMATOR		22d. LOCATION (City, town, or county) (State)	
<b>Family Cemetery</b>		<b>Tangier Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. J. Wilkins</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 20 '58</b>	
ADDRESS <b>Crisfield, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. French</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF INTERVIEW

INTERVIEWER

DATE OF ENTRY

ENTRY NO.

FILE NO.

DATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

EDUCATION

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DATE OF INTERVIEW

INTERVIEWER

DATE OF ENTRY

ENTRY NO.

FILE NO.

DATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12944

CERTIFICATE OF DEATH

12944

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RALEIGH M WARD</b>		4. DATE OF DEATH <b>NOVEMBER 6 19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-7-1878</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HOPE WARD</b>		14. MOTHER'S MAIDEN NAME <b>INDIA PURNELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>SULA WARD</b> Address <b>MARION, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592x Uremia - Acute Dil. of Heart</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>C. Int. nephritis - C. Myocarditis - General arteriosclerosis</b> DUE TO (c) <b>General arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 4, 19 58</b> to <b>Nov. 6, 19 58</b> , that I last saw the deceased alive on <b>Nov. 5, 19 58</b> , and that death occurred at <b>6:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George C. Coulbourn</b> M.D.		ADDRESS (Street, city or town, state) <b>MARION, MARYLAND</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>G. C. COULBOURN, M.D.,</b>		<b>MARION, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 9, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>NOV 10 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

12-1-19

<p>1. NAME OF DECEASED                  JOHN J. BROWN</p>		<p>2. SEX                  MALE</p>	
<p>3. AGE                  65</p>		<p>4. DATE OF BIRTH                  JAN 15 1884</p>	
<p>5. PLACE OF BIRTH                  BOSTON, MASS.</p>		<p>6. OCCUPATION                  LABORER</p>	
<p>7. MARITAL STATUS                  MARRIED</p>		<p>8. DATE OF MARRIAGE                  1905</p>	
<p>9. NAME OF SPOUSE                  MARY J. BROWN</p>		<p>10. DATE OF DEATH                  DEC 1 1949</p>	
<p>11. PLACE OF DEATH                  HOME</p>		<p>12. CAUSE OF DEATH                  HEART DISEASE</p>	
<p>13. MEDICAL HISTORY                  HYPERTENSION</p>		<p>14. SIGNATURE OF PHYSICIAN                  DR. J. H. SMITH</p>	
<p>15. SIGNATURE OF REGISTRAR                  J. H. SMITH</p>		<p>16. OFFICIAL SEAL                  (Seal of the Registrar of Vital Statistics)</p>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

